Finger Lakes
COMMUNITY HEALTH
Taking the time to care.

Health History Form

Last Name: ________________________________ First Name: ________________________ DOB: _________________

Y	N	Allergy	Please Specify
		Medication	
		Latex	
		Food	
		Other	

Medication History	
List your current medications, including birth control, herbal & Vitamins	

Y	N	Personal History Have you ever been told that you have/had:
		High Blood Pressure
		Low Blood Pressure
		Heart Disease
		Kidney Disease
		Blood Disorders or Anemia
		Damaged Heart Valves or Problems
		Artificial Valves or Pacemaker
		Rheumatic Fever
		Congenital Heart Disease
		Heart Murmur
		Surgical Implants
		Artificial Joints
		Hepatitis ◇ A ◇ B ◇ C
		Blood Transfusion
		Sinus Problems
		Cancer
		Diabetes
		Thyroid Disorder
		Weight Loss
		Weight Gain
		Eye Problems
		Tuberculosis
		Asthma
		Stomach Problems
		Persistent Cough
		HIV
		Sexually Transmitted Disease
		Seizure or Epilepsy
		Fainting Spells
		Other (Please specify)

Family History
◇ Adopted ◇ Not Adopted ◇ Unknown

Y	N	Has anyone in your family been diagnosed with:	(Specify who)
		High Blood Pressure	
		Heart Disease	
		Birth Defects	
		Stroke	
		Kidney Disease	
		Blood Disorder	
		Cancer	
		Diabetes	
		Thyroid Disorder	

Y	N	Do you…
		Smoke? How much: Age Started:
		Smokeless Chewing tobacco How much: Age Started:
		Drink liquor? How much: How often: Age Started:
		Use recreational drugs? What kind: How much: How Often: Age Started:

Y	N	Have you/are you
		Have you ever been hospitalized? If yes for what?
		Have you ever had problems with dental treatment? If yes, what happened?
		Have you ever been pre-medicated for dental treatment? If yes w hat medication?
		Do you drink water from a well?
		Does your home water have fluoride?
		Are you pregnant?

I certify that I have read and understood the above questions. My questions about this form have been answered to my satisfaction. I will not hold my Provider or Finger Lakes Community Health responsible for any errors or omissions that I may have made in completing this form.

Signature of Patient or Responsible Party:

X________________________________ Date: ___________

Provider Signature:

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